New Developments in Health Law and Legislation

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In the news…
Uncompensated Care

Sept. 1, 2004, the *Associated Press* reports that proponents of stricter border controls complain that legal immigrants who cannot pay their hospital bills are a huge drain on the medical system. A lawsuit, sponsored by the Friends of Immigration Law Enforcement in Washington, asserts that Los Angeles County is violating federal law by not collecting from immigration sponsors. The group estimates that as a result, taxpayers are being to forced to foot as much as $20 million a year in unpaid bills.

In the news… Millions of Americans Go Without Medical Care.

Sept. 1, 2004, *Modern Healthcare* reports that while 15 million Americans reported going without needed medical care at some point in the past 12 months. Almost 14% of the U.S. population, or roughly 39 million people, reported going without or delaying needed medical care in 2003.

In the news… Surging Charity Care Costs Reason for Layoffs.

Aug. 31, 2004, the *Miami Herald* reports that surging charity costs are to blame for Jackson Memorial Hospital's fourth straight year in the red. Administrators at Miami-Dade County's troubled "safety net" for the poor are planning to lay off up to 500 of the hospital system's 11,000 employees -- a move vehemently opposed by powerful unions. The fiscal year will end with a projected $50 million gap. Next year will be worse.

In the news… California Lawmakers OK Canadian Drug Bill.

Aug. 30, 2004, the *Associated Press* reports that California lawmakers have approved bills that would create government-sponsored Web sites encouraging consumers to buy cheaper prescription drugs from Canada. Federal law prohibits drug imports from other countries, but an estimated 1 million Americans are having their prescriptions filled at Canadian pharmacies at prices as much as 40 percent less than their American counterparts.

In the news… Record Level of Americans Not Insured on Health.

Aug. 27, 2004, nearly every major media outlet, including the *New York Times*, covers the Census Bureau's report that indicates increases in the number of uninsured and people living in poverty during 2003. Rising costs for health coverage and a continuing fall-off in the number of workers in employer-sponsored health plans are among the reasons that a greater number of people did not have health insurance last year, experts say. According to the Census Bureau, the increase in uninsured people last year was 1.4 million, to a record 45 million.

In the news… Hospital's No-Show Nurses Close ER.

Aug. 27, 2004, the *Los Angeles Times* reports that Los Angeles County health officials closed the doors of Martin Luther King Jr./Drew Medical Center to ambulances for more than 60 hours this weekend, in part because of critical staffing shortages. Officials made the move Friday night, declaring an "internal disaster," after large numbers of emergency room nurses called in sick or simply didn't show up for their weekend shifts, said John Wallace, spokesman for the county Department of Health Services. Adding to county officials' concerns, inspectors turned up unexpectedly at King/Drew on Friday for a two-day review. They were focusing in part on problems in the hospital's psychiatric department.

In the news…Hospitals Sued Over Fees to the Uninsured.

Aug. 27, 2004, according the *Philadelphia Inquirer*, the Hospital of the University of Pennsylvania and Children's Hospital of Philadelphia are sued for allegedly overcharging uninsured patients and failing to fulfill their charitable obligations. The hospitals were accused of charging "unreasonable and inflated prices for medical care to... uninsured patients who are all too often impoverished members of the community with little or no means to pay." The complaints, filed in U.S. District Court in Philadelphia, bring to more than 350 the number of hospitals sued by a consortium of law firms led by Richard Scruggs.

In the news… California Uninsured May be in for Discounts.

Aug. 25, 2004, *USA Today* reports that California lawmakers have approved the first bill in the nation to require hospitals to offer discounts to low- and middle-income uninsured patients, responding to complaints that the industry often charges the uninsured the highest prices. The proposal is opposed by the hospital industry and two state agencies. The proposal would require hospitals to offer discounts to uninsured patients who earn up to 400% of the federal poverty level, about $37,000 for a single person or $75,000 for a family of four.

In the news… Whistleblowers Used to Target Fraud.

Aug. 25, 2004, the *Associated Press* reports that thanks to a Civil War era law that offers rewards to people who expose fraud against the government, federal prosecutors have won a series of multimillion dollar settlements. The biggest impact has come in the health care industry, where almost every doctor, hospital and pharmaceutical company has some dealing with federal health programs. The False Claims Act allows people who file the suits on behalf of the government to keep as much as 25 percent of the total recovered. In fiscal 2003, the Department of Justice said it recovered a record $2.1 billion under the False Claims Act. About $1.48 billion of that total came directly from suits initiated by private citizens, who in return reaped $319 million in rewards. The number of whistleblower cases has surged, from 82 in 1990, to more than 300 a year.

In the news… Domino Effect Feared in Los Angeles Emergency Rooms.

Aug. 25, 2004, the *Los Angeles Times* reports that Los Angeles County, which has lost six emergency rooms in a little over a year, is facing more closures that could jeopardize emergency care for tens of thousands of residents. The next round of cuts is expected to target large, heavily used emergency rooms at private hospitals. Good Samaritan Hospital is losing $10 million per year through its emergency room because of an increase in uninsured patients. A third of California's 6.3 million uninsured live in the Southland, and the number is growing rapidly

In the news… Wide U.S. Inquiry Into Health Care Purchasing.

Aug. 23, 2004, the *New York Times* reports that the Justice Department has opened a broad criminal investigation of the medical-supply industry, apparently to determine whether hospitals and other medical care providers are fraudulently overcharging Medicare and other federal and state health programs for a wide array of goods. More than a dozen medical-supply companies received federal subpoenas.

In the news… SEATTLE MAN PLEADS GUILTY IN FIRST EVER CONVICTION FOR HIPAA RULES VIOLATION.

Aug. 19, 2004, Seattle man pleaded guilty in federal court to wrongful disclosure of individually identifiable health information for economic gain. This is the first criminal conviction in the United States under HIPAA. GIBSON admitted that he obtained a cancer patient's name, date of birth and social security number while GIBSON was employed at the Seattle Cancer Care Alliance, and that he disclosed that information to get four credit cards in the patient's name. GIBSON should be sentenced to a term of 10 to 16 months.

In the news… Moody's: Financial Prognosis for Hospitals "Negative."

Aug. 19, 2004, the *Chicago Tribune* reports that Moody's Investors Service indicates that consumer choices and tightening reimbursements from insurance companies are having a negative impact on hospital finances. Moody's placed a "negative outlook" on the not-for-profit health-care sector, citing myriad economic forces that are keeping payments low and patients out of the hospital. In particular, the report said hospitals are suffering from declines in reimbursement from insurers, high expenses and minimal patient volume growth. Hospitals say they are suffering because they are unable to secure large enough rate increases from government and private insurers.

In the news… Doctors, Hospital Settle Rights Suit.

Aug. 18, 2004, the *Los Angeles Times* reports that Community Memorial Hospital and its medical staff announced settlement of a lawsuit that doctors brought against the hospital for allegedly undercutting their rights as a self-governing branch of the medical center. In the settlement, the Trustees agreed that medical staff bylaws could not be changed unilaterally by administrators, agreed to comply with staff bylaws, not to "unreasonably withhold" approval of new medical staff bylaws, and to increase funding for the medical staff. Medical staff agreed not to pursue incorporation as an entity separate from the hospital for at least two years, and agreed to draft their code of conduct and conflict of interest policies requested by the trustees.

In the news… Richard Scrushy Trial Set for Jan 5th.

Aug. 17, 2004, the *Wall Street Journal* reports that Richard M. Scrushy, former HealthSouth Corp. chief executive and chairman indicted for his alleged role in accounting fraud at the company, will go to trial Jan. 5. The grand jury indictment against Scrushy charges him with conspiracy, securities fraud, wire fraud, mail fraud, making false statements, money laundering and providing false certifications to securities regulators in violation of the Sarbanes-Oxley corporate-crime law.

In the news… East Los Angeles Hospital Shuts Emergency Room.

Aug. 13, 2004, the *Los Angeles Times* reports that Elastar Community Hospital in East Los Angeles closed its emergency room this week, and the rest of the hospital might soon follow. The 110-bed hospital has been in operation for nearly 90 years and serves mostly Latino patients. Carol Meyer, director of Los Angeles County's Emergency Medical Services Agency, said "What's going to be significant is the waiting times when you get to the other hospitals that are even busier now because of the volume of people displaced."

In the news… Hospital Faulted for Nurse Staffing.

Aug. 13, 2004, the *San Diego Union Tribune* reports that state inspectors have found that Sharp HealthCare failed to meet nurse-to-patient staffing ratios at three of its San Diego hospitals during breaks and lunches. DHS conducted surprise inspections in May at Sharp Memorial Hospital, Sharp Mesa Vista Hospital and Sharp Mary Birch Hospital for Women. The inspections were conducted based on complaints from the nurses union just prior to contentious labor contract talks. The inspections found that Sharp facilities fell behind nurse-to-patient staffing ratios when nurses took breaks or had lunch, according to inspection records from the department.

In the news… Study: Uninsured Patients Flood Emergency Rooms.

Aug. 10, 2004, *Reuters* reports on a National Association of Community Health Centers study which found that there were 110.2 million visits to hospital emergency departments in 2002, up from 89.8 million in 1998. The study also found that the number of uninsured patients getting care at the centers -- which must provide care regardless of ability to pay -- grew by 11 percent during 2003 alone. "Some health centers are experiencing an explosion of uninsured patients as high as 73 percent, and due to a weakened economy and state budget cuts, no letup is in sight," the report reads. "Fewer doctors open their doors to patients who rely on Medicaid. One-fifth are not accepting any new Medicaid patients," it said. As a result, the estimated 43 million Americans who lack health insurance either go without health care or rely on nonprofit, community centers. Or they visit emergency rooms which, by law, must provide basic, needed care.

In the news… Tenet Says U.S. Seeks Information On Doctor-Relocation Packages.

Aug. 9, 2004, according to the *Wall Street Journal*, Tenet Healthcare Corp. disclosed on Friday that the U.S. attorney's office in St. Louis has requested information about its physician-relocation agreements, the latest sign that the government is conducting a broad review of the hospital chain's doctor-recruitment policies. In San Diego, Tenet's Alvarado Hospital Medical Center was criminally charged a year ago with using the agreements to pay illegal kickbacks to doctors. Tenet has denied wrongdoing.

In the news… Judge Tells County-USC Nurses to End Sick Outs.

July 7, 2004, the *Los Angeles Times* reports that a judge ordered a halt to a series of sickouts by union nurses at Los Angeles County-USC Medical Center, where specially trained burn unit nurses failed to show up for work on the Fourth of July. County health officials successfully petitioned Superior Court Judge Dzintra Janavs for the temporary restraining order on a day when courts and county offices were generally closed. County lawyers argued the sickouts were threatening the health and safety of hospital patients. The order was issued against Local 660 of the Service Employees International Union, though union officials said they had nothing to do with the sickouts.

In the news…Trauma Care Threatened

Sep. 14, 2004, the *Los Angeles Times* reports that the Los Angeles County Board of Supervisors unexpectedly moved to shut down the trauma unit at Martin Luther King Jr./Drew Medical Center. The only public hospital serving a large swath of South Los Angeles, King/Drew treats more trauma patients than any other hospital in the region except County-USC. The proposed closure is expected to take effect in about 90 days. The proposal to shut the hospital's trauma unit is subject to final approval by the county supervisors after a public hearing, which has yet to be scheduled.

FRAUD & ABUSE - 2004

Anti-Kickback Statute: 42 U.S.C. § 1320a-7b(b)

- Criminalizes the payment or acceptance of payment for referral of a person for any item or service for which payment may be made under Medicare or Medicaid (MediCal)
- Felony
- Conviction carries $25,000 fine, 5 years imprisonment; or both

Vigorous Regulatory Enforcement

For FY 2003:

- 243 new civil actions
- 576 convictions
- 3,275 exclusions
- $988 million in “investigative receivables”

OIG Semi Annual Report FY 2004

- $16.8 BILLION savings

New Program Integrity Efforts

- On August 27, 2004 Mark McLellan, CMS Administrator, announced a new CMS initiative to protect Medicare and Medicaid from fraud and abuse.
- Southern California identified as a “fraud hot spot” where unscrupulous individuals systematically defraud the programs.
- CMS to open a satellite office in Los Angeles to focus agency efforts on fraud activities in Southern California.
- CMS reports $260,000 in savings to the Medicare trust fund between January 2003 and June 2004 as a result of stopping fraudulent payments in Southern California.

Advisory Opinions

- 11 Advisory Opinions as of Sept. 9, 2004
- HHS Office of Inspector General:
  http://oig.hhs.gov/fraud/advisoryopinions/opinions.html

2004 Opinions Include:

- Malpractice insurance subsidies (Advisory Opinion 4-11)
- Geriatric group practice employment of primary care physicians (Advisory Opinion 4-09)
- Free vision screening tests for infants (Advisory Opinion 4-04)

Other Guidance

- Draft Supplemental Compliance Program Guidance for Hospitals (guidance on credentialing, substandard care, discounts, co-payments, malpractice subsidies and more)
- Concierge Practices—Physicians cannot charge beneficiaries for special services if services are covered under Medicare

Criminal Law Advisory - 2004

Physician Reporting Requirements

Physician Reporting Requirements

- Felony criminal charges must be reported to the Medical Board of California ("MBC") within 30 days
- Failure to report can result in licensing action against the physician by the MBC
- Even if the physician fails to report, prosecutors and courts are mandatory reporters

Physician Reporting Requirements

- Felony convictions must be reported to the MBC within 30 days
- Failure to report can result in licensing action
- Prosecutors and courts are mandatory reporters

Physician Reporting Requirements

- “Conviction” may include judgment on plea of nolo contendre
- Participation in statutory diversion programs does not protect against independent MBC investigation and possible licensing action
- Courts have no jurisdiction over MBC and cannot enter expungement or other orders to protect physicians in diversion programs

Physician Reporting Requirements

- Best Advice:
- Counsel physician clients to assiduously avoid situations where they might be accused of a crime
- If charged with a felony, hire defense counsel experienced in representing physician clients
- Report all mandated charges and convictions
- Cooperate with MBC

Charity Care/Governance -2004

Nonprofits Under Fire

Charity Care/Governance

IRS “Tax Exempt Compensation Enforcement Project”

- address compensation of specific individuals or questionable compensation practices,
- increase awareness of tax issues as organizations set compensation in the future,
- learn more about the practices organizations are following as they set compensation and report it on their annual Form 990 returns.

Charity Care/Governance

- IRS is seeking information from 2,000 nonprofits
- Project will continue into 2005

Charity Care/Governance

Class actions targeting nonprofits alleges:

- Hospitals charge uninsured patients more than insured patients
- Engage in “aggressive and humiliating collection techniques”

In violation of “contractual promises” made in return for tax exempt status…

Charity Care/Governance

As of Sept. 15, 2004 Scruggs law firm has filed:

- 46 class actions in 22 states
- Seeking injunctive relief and monetary damages and attorneys' fees

Charity Care/Governance

Serious questions yet to be answered:

- Can Scruggs bring a private action to enforce charity care obligations?
- What charity care obligations arise from nonprofit status?
- Legal basis for requiring discounts?
- Is there a class?

Charity Care/Governance

Will the California Legislature set hospital charges for self-pay patients?

Charity Care/Governance

Aug. 17, 2004, Cal. Leg. Approved SB 379 requiring hospitals (except those owned by the State) to develop charity care and reduced payment policies and a reduced payment application…

Charity Care/Governance

- Requires that “charity care” be given to patients whose income is at or below 400% of federal poverty level.
- Caps payment liability to maximum of Medicare, Medi-Cal or Workers’ Comp.

Charity Care/Governance

As of Sept. 15, 2004, SB 232 still under consideration…

- Requires discounts/charity care for families with incomes of up to 700% of federal poverty levels

Charity Care/Governance

2004 Federal Poverty Guidelines:

Family Size	Poverty Guideline
1	$9,310
2	$12,490
3	$15,670
4	$18,850

Charity Care/Governance

So, SB 379 could require charity care or discounts be given to uninsured families of

1	with an income of	$37,240
2		$49,960
3		$62,680
4		$75,400

Charity Care/Governance

And…

SB 232 could require charity care or discounts be given to an uninsured family of four with an income of $131,950

EMTALA - 2004

Emergency Medical Treatment and Active Labor Act

(aka Patient Anti-Dumping Statute)

42 USC § 1395dd

42 CFR § 413.65 et seq.

EMTALA

Old News: A hospital with an emergency department must generally:

- Provide a medical screening examination and
- Stabilizing treatment
- To any individual who presents at the hospital and requests emergency medical services or who is in active labor

EMTALA

Purpose is to prevent hospitals from denying emergency medical services based on payor class.

EMTALA

What's new:

- CMS revised EMTALA regulations in Sept. 2003, effective Nov. 10, 2003
- Interpretive Guidelines published March 13, 2004

EMTALA

Nov. 2003 Regulations:

- Dedicated Emergency Department
- Comes to the Emergency Department and Prudent Layperson Observer Standard
- When does EMTALA end?
- Financial Inquiries

EMTALA

Where does EMTALA apply?

- Old concept of off-campus departments withdrawn
- Replaced with concept of “dedicated emergency department”

EMTALA

A “dedicated emergency department” is a hospital department or service that is:

- Licensed under state law as an emergency department
- “Held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”

EMTALA

- A department or service that "based on a representative sample of patient visits" that occurred during the previous year, the department provides "at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment."

EMTALA

2004 Guidelines provided a methodology for determining two-thirds threshold

- Complex and detailed directions to surveyors to select patient samples

EMTALA

Prudent Layperson Observer: EMTALA applies if an individual "comes to the emergency department" or if the individual presents at another area of the hospital and a "prudent layperson observer" would believe that the individual needs emergency examination and treatment.

EMTALA

When does EMTALA end?

- New regulations clarify that a hospital's EMTALA obligations end when a patient is admitted.

EMTALA

New regulations extend prohibition on financial inquiries:

- The hospital may NOT seek authorization from a patient's insurance company until after the hospital has provided a medical screening examination and initiated necessary stabilizing treatment

EMTALA

But the hospital may follow a "reasonable registration process"

- May include asking if the patient has insurance so long as this does not delay screening or treatment
- May not "unduly discourage" individuals from remaining for further evaluation
- 2004 Guidelines provide no guidance

Employment Advisory

Nurse/Patient Ratios

Nurse/Patient Ratios

- Gov. Davis proposed minimum nurse to patient ratios back in Jan. 2002
- Ratios took effect Jan. 1, 2004
- No consensus on whether minimum staffing ratios improve patient care or outcomes
- Highly contentious union issue
- Enormous cost increases to hospitals in face of nurse shortages

Nurse/Patient Ratios

- ICU/CCU 1:2
- OR 1:1
- NICU 1:2
- Well-baby nursery 1:8
- Postpartum 1:8 (couples)/1:6 (mothers only)
- L&D 1:2
- Post Anesth 1:2
- ED 1:4
- ED Critical Care 1:2
- ED Trauma 1:1
- Burn Units 1:2
- Peds 1:4
- Psych 1:6

Nurse/Patient Ratios

- Step down/tele 1:4 (1/1/08 1:3)
- Oncology 1:5 (1/1/08 1:3)
- Telemetry 1:5 (1/1/08 1:4)
- Med/Surg 1:6 (1/1/05 1:5)

Nurse/Patient Ratios

For purposes of the ratios:

- "Licensed nurses" are RNs, LVNs, LPTs (for psych units only)
- Nurse must be competent and oriented to the unit to be counted
- LVNs may not exceed 50% of nurses in most cases but some unites (e.g., NICU) require 100% RNs

Nurse/Patient Ratios

- Ratios apply AT ALL TIMES
  - During lunch and during break times
  - Ratios may not be averaged over shifts
- Generally cannot count charge nurses that have administrative duties/not assigned to specific patients

Nurse/Patient Ratios

- Noncompliance may be discovered during surveys and is complaint driven
- No new penalties: DHS issues citations and requires a plan of correction
- Unions have attempted to get monetary penalties but Gov S has refused to sign

Nurse “Zero Lift” Law

- AB 2532 would implement “zero lift” policy prohibiting hospitals from allowing nurses to lift or transfer patients
- Would require specially trained lift teams
- Passed Senate on Aug. 27, 2004

ERISA - 2004

Aetna v. Davila; Cigna v. Calad

- U.S. Supreme Court held that ERISA completely preempted two cases under the Texas Healthcare Liability Act, which makes a health plan liable for harm to an enrollee caused by the failure to exercise ordinary care in making healthcare treatment decisions.

Aetna & Cigna Cont.

- HMO cases have generally been considered preempted by ERISA when the plaintiff's coverage is from an ERISA plan, i.e., an employee benefit plan. The actions are interpreted to be actions for plan benefits and are decided in Federal Court under ERISA which limits damages to the value of the benefits denied and provides no consequential damages.

Aetna & Cigna Cont.

- Davila is based on a specific state authorizing statute which casts the issue as one of malpractice by the HMO. The Texas law purported to carve out an area of HMO decision-making that it described as "medical" rather than relating to administration of plan benefits.

Aetna & Cigna Cast Doubt on Calif. Managed Heathcare Insurance Accountability Act of 1999

Civil Code § 3428: health plans have a duty of ordinary care to arrange for the provision of medically necessary healthcare services to their enrollees and are liable for any and all harm legally caused by their failure to exercise such ordinary care when:

- the failure to exercise ordinary care results in the denial, delay or modification of the healthcare services recommended for, or furnished to an enrollee and
- The enrollee suffers substantial harm as a result.

Patient Care/Bioethics - 2004

New California laws in 2004 and what's to come…

Patient Care/Bioethics

Stem Cell Research

- New in 2004:
  - SB 771 amending H&S 125115 et seq.
    - Requires DHS to establish and maintain anonymous registry of embryos available for research
    - Failure to provide to individuals undergoing fertility treatment information on embryo donation to research is unprofessional conduct

Patient Care/Bioethics

Nov. Ballot Measure:

- Prop. 71 Stem Research. Funding. Bonds. Initiative Constitutional Amendment and Statute:
  - Establishes “California Institute for Regenerative Medicine” to regulate & fund stem cell research
  - Prohibits reproductive cloning

Patient Care/Bioethics

- Authorizes $3 billion in state tax-exempt bonds
- Funds will be allocated incrementally over 10 years (~$295 million per year) for California based stem cell research at universities and research institutions

Patient Care/Bioethics

Informed Consent to Participate in Research

- AB 1371 amended H&S Code Sections 24173, 24176 and 24178
- Increases the standards for informed consent to participate in research
- Requires institutions to disclose financial interests in outcome of research
- Establishes penalties for both institutions and investigators

Patient Care/Bioethics

Healthcare Coverage

- SB 2 created the State Health Care Purchasing Program
- Now Infamous statutory enactment that requires employers to purchase healthcare coverage for workers
- Nov. Ballot—Prop. 72 will Repeal

Patient Care/Bioethics

Hospitals Required to Post Chargemaster

- AB 1627 added H&S 1339.50 et seq.
- Requires hospitals to post charges for 25 services most commonly charged to patients
- Will patients shop around for care?

Patient Care/Bioethics

Physician Cultural/Linguistic Competency

- AB 801added B&P 2198 et seq.
- Establishes Cultural and Linguistic Physician Competency Program
- CMA and local medical societies to offer classes to teach physician about cultural practices that impact healthcare

Patient Care/Bioethics

Physician Licenses

- AB 236 added B&P 2232
- Prohibits registered sex offenders from being licensed as a physician

Patient Care/Bioethics

Patient's Rights

- SB 577 amended Civil Code and W&I
- Protection & Advocacy Agencies given expanded authority to advocate for rights of "people with disabilities"
- Previously only applied to mentally ill and developmentally disabled persons
- Expands PAI's unaccompanied access to patients and records
- Allows unaccompanied access to investigate abuse

Patient Care/Bioethics

Genetic Testing

- SB 200 added Ins. Code Section 10233.1
- Prohibits until 1/1/08, long term car insurers from using genetic testing to determine insurability

Patient Care/Bioethics

Informed Consent to Pelvic Exams

- AB 663 added B&P 2281
- Restricts physician or student from performing pelvic exam on anesthetized or unconscious women unless:
  - Patient gave informed consent;
  - Exam is within scope of care;
  - If unconscious, exam required for diagnostic purposes

Patient Care/Bioethics

Mental Health Services Funding

- Nov. Ballot Measure
- Prop 63: Establishes 1% income tax on personal income over $1M to fund services for mentally ill children, adults, seniors

Managed Care Litigation Advisory

Recent Provider Payment Cases

Managed Care Litigation Advisory

- Thousands of health care providers are not contracted with health plans
- California's HMO regulatory statute – Knox-Keene mandates payment of non-contracted physicians but does not specify private enforcement actions
- Non-contracted physicians have historically used Knox-Keene and common law theories to sue for recovery of unpaid medical charges

Managed Care Litigation Advisory

- *Desert Health Care v. Pacificare, et al.* (November 30, 2001), and *California Medical Association v. Aetna, et al.* (December 5, 2001)
- Knox-Keene does not impose independent obligation on health plans to pay for care provided by non-contracted providers where plans delegated payment responsibility to risk bearing intermediary

Managed Care Litigation Advisory

- *Chase Dennis Emergency Medical Group Inc. v. Aetna U.S. Health Care of California, Inc.* (unpublished); *California Emergency Physicians Medical Group v. Pacificare of California* (2003)
- Separate Knox-Keene provision mandating payment of non-contracted emergency room physicians is not enforceable in private litigation where health plans have delegated payment responsibility to risk bearing intermediaries

Managed Care Litigation Advisory

- *Ochs v. PacifiCare of California* (2004)
- Bus. & Prof. Code section 17200 claims brought by non-contracted providers rejected

Managed Care Litigation Advisory

- Pending legislation – SB 1569
- Would amend Knox-Keene to specifically permit certain private enforcement actions

Malpractice Insurance Crisis 2004

California's Historical Experience - MICRA

- Enacted in 1975
- Intended to address malpractice insurance crisis
- Model for Bush administration's liability reform proposals

MICRA

- 1. Mandates a $250,000 cap on noneconomic damages ONLY. (Civil Code § 3333.2)
- 2. Allows introduction into evidence of collateral sources of payment. (Civil Code § 3333.1)
- 3. Allows periodic payments of future damages. (CCP § 667.7)
- 4. Provides for a sliding scale limit on attorneys' contingency fees. (B&P § 6146)

MICRA Cont.

- 5. Provides for a shorter statute of limitations. (CCP § 340.5)
- 6. Requires a 90-day "Notice of Intent to Sue." (CCP § 364)
- 7. Encourage and facilitate arbitration. (CCP § 1295)

Lathrop v. Health Care Partners Medical Group (1/21/04)

- MICRA cap applies to a medical group even the group is not a healthcare provider, by virtue of the doctrine of *respondeat superior*.

Elder Abuse Exception

Covenant Care, Inc. v. Superior Court

(2004) 32 Cal. 4th 771

MICRA's procedural safeguards for punitive damages do not apply to actions alleging elder abuse under the Elder Abuse and Dependent Adult Civil Protection Act (Welfare & Institutions Code § 15600 et seq.)